Trodelvy (sacituzumab govitecan-hziy)

Member and Medication Information (required)	
Member ID:	Member Name:
DOB:	Weight:
Medication Name/ Strength:	Dose:
Directions for use:	

Provider Information (required)		
Name:	NPI:	Specialty:
Contact Person:	Office Phone:	Office Fax:

FAX FORM AND RELEVANT DOCUMENTATION INCLUDING: LABORATORY RESULTS, CHART NOTES and/or UPDATED LETTER OF MEDICAL NECESSITY TO 855-828-4992

Criteria for Approval: *(all of the following criteria must be met)*

- ❑ Diagnosis of one of the following:
  - Unresectable locally advanced or metastatic triple-negative breast cancer (mTNBC). Chart Note Page #: _____
  - Locally advanced or metastatic urothelial cancer. Chart Note Page #: _____
- ❑ Prior Therapy:
  - Unresectable locally advanced or metastatic triple-negative breast cancer: Use of at least two systemic therapies, at least one of them for metastatic disease.
  - Locally advanced metastatic urothelial cancer: Use of platinum-containing chemotherapy and PD-1 or PD-L1 inhibitor.

Medication/Dose	Details of Therapy	Chart Note Page #

- ❑ Trodelvy will not be used with other drugs containing irinotecan or its active metabolite SN-38.
- ❑ Plan to monitor absolute neutrophil count (ANC) for counts below 1500/mm^3 or neutropenic fever at baseline and periodically during treatment. Chart Note Page #: _____

Re-authorization Criteria:
Updated letter of medical necessity or updated chart notes demonstrating positive clinical response.

Initial Authorization: Up to six (6) months
Re-authorization: Up to one (1) year

PROVIDER CERTIFICATION
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____
Prescriber's Signature Date